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# SKILLED NURSING FACILITY CONTINUED STAY REQUEST FORM

*PLEASE FAX THIS FORM ALONG WITH REQUIRED INFORMATION TO: 833-311-2986*
*Questions? Call 844-411-9622*

| Date of Request: | ☐ Standard<br>☐ Retro | ☐ Urgent Request:<br>*Note: Expedited organization determinations (urgent requests), can only be requested by the Member, Member Representative, or a Physician and only if applying the standard timeframe could seriously jeopardize the life or health of the member. (see CMS regulation: 40.8)* |
|---|---|---|

| *Member Information:* | | |
|---|---|---|
| Member Name: | Member ID: | Date of Birth: |

| *Requesting Facility Information:* | | |
|---|---|---|
| Facility Name: | | |
| NPI: | Attending Physician: | Is there a medical power of attorney?<br>☐ Yes ☐ No ☐ Unknown |
| Phone: | Attending Physician NPI: | |
| Fax: | | Name and relationship to patient: |
| SNF Facility Contact Name: | SNF admission date: | |
| SNF Facility Contact Phone: | Anticipated SNF Discharge date: | *If available, please attach POA/AOR with request* |
| SNF Facility Contact Fax: | Is member currently in your facility? ☐ Y ☐ N | Does the patient have an advanced directive?<br>☐ Yes ☐ No ☐ Unknown |

Submission MUST include the following as part of your referral package:
☐ All pages of this referral form (fully completed – include comments).
☐ SNF H & P
☐ Specialty consultations
☐ Overall plan of care
☐ Admission Orders
☐ Current medication list/record
☐ Interdisciplinary Team Assessment (if completed)
☐ 3 days of most recent physician notes.
☐ 1-2 days of most recent nursing notes.
☐ 1-2 days of most recent wound care notes, if applicable.
☐ Therapist assessment/ current progress notes that provide relevant supplemental information.
(e.g., cognitive assessment scores, strength/motor recovery information) for PT/OT/ST.
☐ Most recent diagnostics (CT scans / X-ray reports) and lab work.

| Admitting ICD-10 Code(s) | | | |
|---|---|---|---|
| 1(Primary) | 2 | 3 | 4 |

| Clinical Category | | | |
|---|---|---|---|
| ☐ Acute Neurologic | ☐ Wound | ☐ Major Joint Replacement or Spinal Surgery | ☐ Other |
| ☐ Acute Infections | ☐ Medical Management | ☐ Orthopedic Surgery (Except - Major Joint or Spinal Surgery) | ☐ Unknown |
| ☐ Cardiovascular | ☐ Cancer | ☐ Non-Surgical Orthopedic/Musculoskeletal | |
| ☐ Pulmonary | ☐ General weakness/deconditioning | ☐ Non-Orthopedic Surgery | |
| Reason For Continued Skilled Stay:<br><br>Other Medical Conditions: | | | |

*Prior Level of Function Immediately Before Hospital Stay: Only fill in if not previously completed.*

| Ambulation: | # Feet: | □ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown |
|---|---|---|
| | Wheelchair Mobility: | □ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown □ N/A |
| | Transfers: | □ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown |
| | Grooming/Hygiene: | □ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown |
| | Bathing: | □ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown |
| | Dressing: | □ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown |
| Previously used DME: □ W/C □Walker □Cane □ Brace □Bedside Commode □Bath/Shower Chair □ Brace □ Unknown<br>□Other (describe): | | |

*Current Orders:*

| | |
|---|---|
| ☐ Medical and/or nursing care | Frequency: □ Daily □ Every other day □ Weekly □ Unknown |
| ☐ Physical therapy to address functional impairment | Frequency: □ 1-2x/wk □ 3-4x/wk □ 5x/wk □ Unknown |
| ☐ Occupational therapy to address functional impairment | Frequency: □ 1-2x/wk □ 3-4x/wk □ 5x/wk □ Unknown |
| ☐ Speech therapy to address functional impairment | Frequency: □ 1-2x/wk □ 3-4x/wk □ 5x/wk □ Unknown |

**Most recent vitals:** Temp _________ Pulse ________ RR _________ BP __________ O2 sat _________ Weight ________ Height ________

*Barriers to Discharge:*

**If there are medical barriers to discharge, please document below:**

| | |
|---|---|
| □ Respiratory Care | □ Naso-pharyngeal or deep tracheal suctioning<br>□ Ventilator management and/or weaning<br>□ Nebulizer treatments ≥ 2 times/day<br>□ Tracheotomy present |
| □ IV/IM Medications | □ IV medication ≥ 2 times/day that patient cannot self-administer. Patient does not have assistance at home and cannot practically travel to an infusion center.<br>□ IM medication ≥ 2 times/day and patient cannot self-administer.<br>□ Central line or multiple peripheral IV lines<br><br>Type of line: Insertion Date:<br>Medication: Name: Dosage: Frequency:<br>Estimated stop date: MM/DD/YYYY |
| □ Nutritional Support | Diet Type ☐NPO ☐TF ☐TPN ☐Oral □Mechanical Soft □ Pureed □ Other:<br>Route ☐ NG ☐ PEG ☐J Tube☐ Dobhoff Insertion date:<br>Formula: Amount/Rate:<br><br>□ Initiation of tube feedings ≥ 500 ml daily or ≥ 26% of daily caloric intake is required.<br>□ Initiation of intravenous (TPN) feeding requires skilled nursing care. |
| □ Ostomy Care | □ Colostomy care during the early post-operative period (≤ 14 days from surgery) in the presence of complications requiring skilled nursing care. |
| □ Urinary | □ Initial clinical management of a urinary catheter (suprapubic or "in and out" catheterization) is required.<br>□ Individual or caregiver requires complex teaching services that can only be delivered in a 24-hour SNF setting and cannot be completed at home. |

| | | |
|---|---|---|
| □ Wound Care | □ Multiple Stage II □ Stage III or IV Decubitus Wound(s)<br>□ Other wound(s) that require(s) multiple dressing changes within a 24-hour period<br>Wound Vac: ☐Yes ☐No<br><br>**Please answer for each wound:**<br><br>**Location**:<br>Date of Measurement:<br>Size: L x W x D (cm) = _______x ________x _______<br>Stage:<br>Description:<br><br>Treatment: | **Location:**<br>Date of Measurement:<br>Size: L x W x D (cm) = _______x ________x _______<br>Stage:<br>Description:<br><br>Treatment:<br><br>**Location**:<br>Date of Measurement:<br>Size: L x W x D (cm) = _______x ________x _______<br>Stage:<br>Description:<br><br>Treatment: |
| Dialysis: ☐Yes ☐No | ☐ Acute ☐ Chronic ☐ HD ☐ Peritoneal<br><br>Frequency: Access: | |
| □Other | Describe: | |
| Comments: | Please use this space to provide additional detail on ongoing needs for skilled nursing care: | |

If there are physical barriers to discharge, please document below:

| | | |
|---|---|---|
| Date of Current Therapy Status: | | |
| Weight Bearing Status: | | □ FWB □ WBAT □ PWB □ NWB □Unknown |
| Ambulation: | # Feet: | □ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown |
| Wheelchair Mobility (if applicable): | | □ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown |
| Bed Mobility: | | □ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown |
| Transfers: | | □ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown |
| Stairs: | # Stairs: | □ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown |
| Feeding: | | □ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown |
| Grooming/Hygiene: | | □ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown |
| Bathing: | | □ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown |
| Dressing: | | □ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown |
| Toileting: | | □ Independent/Mod I □Supervision □ CGA □ MINA □ MODA □ MAXA □ DEP □ Unknown |
| Additional DME required for discharge: □ W/C □Walker □Cane □ Brace □Bedside Commode □Bath/Shower Chair □ Brace □ Unknown<br>□Other (describe): | | |

**If there are Cognitive/Mood/Speech barriers to discharge, please document below:**

**Mental Status:** Baseline________________________ **Current**: Oriented X __________:
**Level of consciousness:** □ awake and alert □ lethargic □ confused □ delirious □agitated □ obtunded
**Other**: □dementia □ short term memory deficits □ long term memory deficits □ unable to follow 1-2 step commands □ depression □anxiety
**Speech:** □ expressive aphasia □ receptive aphasia □ apraxia □ dysarthria
**Comment:**

Care Conference Date/Discussion:

| Discharge Planning (general): | |
|---|---|
| **Previous living situation** □ Home alone □ Home with spouse □ Home with family/caregivers □Long Term Care □ Supportive housing □ Homeless □ Unknown □ Other (comment}:<br><br>**Planned d/c living situation** □ Home alone □ Home with spouse □ Home with Family/Caregivers □Long Term Care □ Supportive housing □ Unknown □ Other (comment}: | |
| For discharge plans to return home: | For discharge plans to long term care or supportive housing: |
| Is there a caregiver identified and able to assist the patient?<br>□Yes □No □Unknown<br>[IF YES] □ 24hrs □ Daytime only □ Evening Only<br>[IF YES] Caregiver ability to provide care:<br>□ Grocery Shopping □ Meal Prep □ Non-Transfer Assistance (feeding/dressing) □ Transfer Assistance (in/out of bed, toileting) □ Full ADL Assistance<br>[IF YES] Is it anticipated that the caregiver(s) can be adequately trained to meet the patient's care needs fully and safely? □Yes □No □ Unknown<br>[IF YES] Has caregiver training been completed? □Yes □No □ Unknown<br><br>Home Living Environment:<br># of steps to enter: ____________ Rails: □Yes □No □ Unknown<br>Is there a ramp to enter? □Yes □No □ Unknown<br>Bed 1st Floor □Yes □No □ Unknown<br>Bath 1st Floor □Yes □No □ Unknown<br>Is there ability for first floor setup? □Yes □No □ Unknown<br><br>If d/c plan includes home health, has patient been referred to a home health agency willing to accept the patient? □Yes □No □ Unknown<br>If yes, Name of Company: | Has a facility been chosen? □ Yes □ No □ LTC resident □ Unknown<br>[IF YES] Name of facility:<br>Has an application been completed? □ Yes □ No □ LTC resident □ Unknown<br>Is it anticipated that a bed/room be available for the patient?<br>□ Yes □ No □ Unknown<br>Is it anticipated that the facility will be able to provide the level of care needed at discharge? □ Yes □ No □ Unknown<br>Does patient require an application for Medicaid? □ Yes □ No □ Unknown<br><br>Discharge Plan Comment: |

Additional Comment:

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